

EMPLOYEE'S REPORT OF CLAIM

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

1. Social Security Number		2. Date of Injury		3. Date of Birth (MM/DD/YYYY)		4. Employee Telephone Number	
5. Employee Name				6. Employer Name			
7. Employee Street Address				8. Employer Street Address			
9. Employee City		10. State	11. ZIP Code	12. Employer City		13. State	14. ZIP Code
15. Describe the type of injury and explain how it happened. (If a medical report is available, please attach a copy)							
16. Are you making a claim for payment of medical expenses? Yes No If yes, please attach a copy of medical bill(s) if available				17. Last Day Worked			
18. Have you gone back to work? Yes No If yes, date of return _____				19. Was the injury reported to your employer? Yes No If yes, what date was it reported? _____			
20. Employee Signature				21. Date of this report			

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, R408.31(4)
Completion: Voluntary
Penalty: None

OFFICE USE ONLY

Carrier Name	NAIC Number	Federal ID Number
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The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc. under the Americans with Disabilities Act, you may make your needs known to this agency.